SOUTH DAKOTA BOARD OF NURSING
SOUTH DAKOTA DEPARTMENT OF HEALTH
4305 S. LOUISE AVENUE SUITE 201 ♦ SIOUX FALLS, SD 57106-3115
(605) 362-2760 ♦ FAX: 362-2768 ♦ www.state.sd.us/doh/nursing

REACTIVATION FOR ADVANCED PRACTICE NURSE (APN) LICENSE

❒ CERTIFIED NURSE MIDWIFE (CNM)
❒ CERTIFIED NURSE PRACTITIONER (CNP)
❒ CERTIFIED REGISTERED NURSE ANESTHETIST (CRNA)
❒ CLINICAL NURSE SPECIALIST (CNS)

The APN may request reactivation of a license which has been voluntarily placed on Inactive Status.
FEES: $70 Reactivation Fee. All fees are non-refundable.

To reactivate your CNM, CNP, CRNA, or CNS license:

- You must be actively licensed as a Registered Nurse.
  - ❒ If South Dakota is your primary state of residence, or if you reside in a non-compact state and your South Dakota RN license is active, you have satisfied this requirement.
  - ❒ If South Dakota is your primary state of residence, or if you reside in a non-compact state and your South Dakota RN license is not active, you must Reactivate or Reinstate your South Dakota RN license and pay the appropriate RN licensure fees.
  - ❒ If you reside in a Compact State and your RN license in that state is active, please send a copy of that active RN license to be verified by the SD Board of Nursing.
- Complete and submit the APN Reactivation Application.
- Complete and submit Verification of Certification Form. You are responsible to maintain current certification throughout your licensure renewal cycle and to provide evidence to the Board of current certification. When filing your recertification paperwork, provide a Verification of Certification form to the certifying body along with appropriate payment, requesting that verification of your new certification expiration date be forwarded to the Board office.

NOTE: You are exempt from the **CNM/CNP** certification requirement if you were originally licensed as a CNM/CNP in South Dakota prior to June 26, 1996 and have never submitted certification evidence to the Board for licensure purposes.
You are exempt from the **CNS** certification requirement if you were originally licensed as a Clinical Nurse Specialist in South Dakota prior to July 1, 1996 and have never submitted certification evidence to the Board for licensure purposes.

COLLABORATIVE AGREEMENT: **CNMS AND CNPS ONLY**

CNM: You may perform the overlapping scope of advanced nursing practice and medical functions as defined in SDCL 36-9A-13 and complete and submit a CNM Collaborative Agreement.

CNP: You may perform the overlapping scope of advanced practice nursing and medical functions as defined in SDCL 36-9A-12 and complete and submit a CNP Collaborative Agreement.

If it is still in your possession, please return the Inactive Status card to the South Dakota Board of Nursing.

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REACTIVATION FEE $70

ADVANCED PRACTICE NURSE REACTIVATION APPLICATION

❒CERTIFIED NURSE MIDWIFE (CNM) ❒CERTIFIED NURSE PRACTITIONER (CNP)
❒CERTIFIED REGISTERED NURSE ANESTHETIST (CRNA) ❒CLINICAL NURSE SPECIALIST (CNS)

I wish to reactivate my South Dakota APN license # _____

APPLICANT NAME: _____
FIRST MIDDLE MAIDEN LAST OTHER NAMES

ADDRESS: _____
STREET OR PO BOX CITY COUNTY STATE ZIP

SOCIAL SECURITY # _____ RN STATE/LICENSE # _____ EXPIRATION DATE: _____
❒MALE ❒FEMALE DATE OF BIRTH: _____ TELEPHONE: _____ EMAIL: _____

CERTIFICATION INFORMATION: ❒ I am exempt from Certification because _____.
❒ I have current Certification information on file with the Board.
❒ I am submitting Verification of Certification with this Application.

CNM ONLY: ❒ I am not filing a Collaborative Agreement with the Boards; I do not perform overlapping scope of practice nursing and medical functions as defined in SDCL 36-9A-13.
❒ I am submitting a new CNM Collaborative Agreement for review and approval by the Boards.

CNP ONLY: ❒ I am not filing a Collaborative Agreement with the Boards; I do not perform overlapping scope of practice nursing and medical functions as defined in SDCL 36-9A-12.
❒ I am submitting a new CNP Collaborative Agreement for review and approval by the Boards.

DISCIPLINARY INFORMATION			
1.	Have you ever been convicted, pled no contest/nolo contendere, pled guilty to, or been granted a deferred judgment or sentence with respect to a felony, misdemeanor, or petty offense other than minor traffic violations? **If YES, provide a signed and dated explanation. You must also submit copies of charges or citations and All communication with (to and from) the citing agency AND the court of jurisdiction, including evidence of completion/compliance with court requirements.**	❒YES	❒NO
2.	Is there any pending criminal prosecution against you which would constitute a felony?	❒YES	❒NO
3.	Are you currently being investigated or is disciplinary action pending against any professional license(s) or certificate(s) held by you?	❒YES	❒NO
4.	Has any nursing license or certificate ever held by you in any state or country been denied, revoked, suspended, stipulated, placed on probation, or otherwise subjected to any type of disciplinary action?	❒YES	❒NO
5.	Have you ever had privileges revoked, reduced, or otherwise restricted at any hospital or other healthcare provider entity?	❒YES	❒NO
6.	Have you ever been subject to proceedings by a professional society to revoke, reduce, or restrict membership?	❒YES	❒NO
7.	Within the last two years, have you been treated for abuse or misuse of any alcohol or chemical substance?	❒YES	❒NO
8.	Within the last two years, have you experienced a physical, emotional, or mental condition that has endangered the health or safety of persons entrusted in your care?	❒YES	❒NO
9.	Do you currently owe child support arrearages in the sum of $1,000 or more?	❒YES	❒NO

For 2-9 above, provide an explanation for each YES response on a separate piece of paper, with a complete description of dates and circumstances. You must also send ALL supporting applicable documents.

DECLARATION OF PRIMARY STATE OF RESIDENCE AND AFFIDAVIT

❒I declare that my primary state of residence (where I hold a driver's license, pay taxes, and/or vote) is _____.
This is my "home state" under the Nurse Licensure Compact and my "declared fixed permanent and principal home for legal purposes."
- OR –
❒ I am employed by the federal government, and so am not affected by the Nurse Licensure Compact requirements regarding Primary State of Residence. Name of Employer: _____.

I declare and affirm under penalties of perjury that this application for nurse licensure in South Dakota has been examined by me and, to the best of my knowledge and belief, is in all things true and correct.

_____ _____
APPLICANT SIGNATURE DATE

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CERTIFICATION VERIFICATION FORM

Complete items 1 – 8 on this form, then forward to the form to the certification organization.

Please Print

1. Name: First_____ Middle_____ Last _____
2. Other names previously used:_____
3. Address:_____
   Street/PO Box City State Zip
4. Name of Certification Organization_____
5. Certification #_____ Expiration Date_____
6. Certification status (check one): ❑ Initial certification verification ❑ Recertification verification
7. Certification type (check one): ❑ CRNA ❑ CNS ❑ CNM ❑ CNP
8. Consent to *Release Information* to the South Dakota Board of Nursing:

   I authorize the above named certification organization to disclose information regarding the identification, evaluation, and certification of the above named applicant that is maintained by the above named certification organization to the South Dakota Board of Nursing. I authorize the South Dakota Board of Nursing to utilize this information as needed for validation, investigation, litigation, discipline, or agreements concerning my nursing license. This authorization to release requested information shall expire at my written request. A copy of this request shall be as effective as the original.

_____ _____
Applicant Signature Date

Certification Organization: complete below then forward to South Dakota Board of Nursing at address above.

NAME OF CERTIFICATION ORGANIZATION_____

Certification #	Date of Current Certification Maintenance Cycle/Recertified through:
Certification type: ❑ CNM ❑ CNS – specialty area_____ ❑ CRNA ❑ CNP – specialty area_____	
Is certification current? ❑YES ❑NO (Please explain on a separate paper)	Has certification lapsed? ❑YES (Please explain on a separate paper) ❑NO
Has certification been revoked? ❑YES (Please explain on a separate paper) ❑NO	Is certification provisional/conditional in any manner? ❑YES (Please explain on a separate paper) ❑NO

_____/_____ _____
Name/Signature of person completing form Title Date